MERCER

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CONNECTICUT HEALTH INSURANCE EXCHANGE BOARD MEETING

December 15, 2011

Mercer
2325 East Camelback, Phoenix, AZ 85016

MARSH & McLENNAN COMPANIES

Agenda

- Introduction of the Mercer team
- Goals for today
- Focused discussion on the following tasks:
  - Task 4 – Economic and actuarial modeling including the Basic Health Program (BHP)
  - Task 5 – Large employer market (>100 employees) in the Exchange after 2017
  - Task 7 – Review a financial model for the HIE
  - Task 6 – Interaction with other coverage initiatives
- Next steps

The Patient Protection and Affordable Care Act (PPACA)

- Provisions to create new competitive private health insurance markets known as Exchanges
- Intent of the PPACA is that starting in 2014 Americans will have access to health coverage through these newly established Exchanges
- Flexibility in the design and implementation of an Exchange – state specific
- Small Business Health Options Program (SHOP)
- Purchase affordable health insurance from a choice of products offered by qualified health plans that facilitates competition and choice

TASK 4

Conduct economic and actuarial modeling and analyses to project trends such as the number of newly insured, the impact of certain market changes on premium levels and the implications of different policy questions

Health care reform micro-simulation model for Connecticut
Background

- Primary data sources:
  - American Community Survey (ACS), adjusted to health insurance units (HIU) used for insurance coverage, family relationships, income and type of employer
  - Dunn & Bradstreet data used for employer size and industry
  - Current Population Survey used for morbidity (self-reported health status)
  - Supplemental Health Care Exhibits from carrier annual statements used for market sizing and premiums per member per month (PMPM)
  - Carrier data call used for carrier rating practices, demographics, actuarial value of benefits being offered, validating external data
  - Carrier rate filings from Connecticut Insurance Department used for rating practices and market sizing
  - MEPS data for employer offer rates and for enrollment by group size

Health care reform micro-simulation model for Connecticut
Methods

- Three-step process:
  - Step 1: Populate the model with the following information:
    - Family make-up
    - Coverage eligibility (Medicaid, individual, group, and if group, which group)
    - Morbidity assigned using simulation
    - 2010 premiums assigned via simulation based on carrier rating manuals and Supplemental Health Care Exhibits
    - 2014 premium rate shock from PPACA provisions
      - Includes adjusted community rating, essential health benefit package, mandated benefits, temporary reinsurance program, etc.
      - 12.9% increase for individual, 4.5% for group

Health care reform micro-simulation model for Connecticut
Methods (cont'd)

- Three-step process:
  - Step 2: Calibrate model to fit Connecticut experience from 2010
    - Solve for elasticity and utility function parameters that reproduce the current Connecticut market
    - Ensure consistency with known data in Connecticut – number of insured by market, number of uninsured, premiums and claims PMPM by market, etc.

Population	Known distribution	Modeled distribution
Uninsured <200% FPL	25.5%	24.5%
Uninsured 200%–400% FPL	10.5%	10.7%
Uninsured >400% FPL	5.4%	6.6%
Individual Purchase	14.1%	14.7%
Small Group (1–50)	31.8%	31.1%
Mid-Size Group (51–100)	12.7%	12.4%
Total	**100.0%**	**100.0%**

Health care reform micro-simulation model for Connecticut
Methods (cont'd)

- Three-step process:
  - Step 3: Migration Model
    - Model behavior and selection among various choices available
      - Individuals currently enrolled in Medicaid and Medicare, or who have coverage through the military or federal or state government in 2010 are assumed to retain coverage through those programs
      - Large group coverage is also assumed to remain intact, so we have not modeled the behavior of large groups
      - HIU income is used to evaluate eligibility for programs such as Medicaid, CHIP, and premium and cost sharing subsidies
      - Small groups buy down coverage to Bronze, shift costs to employees, then lapse
      - Model assumes HIUs will make decisions that maximize their utility

$$U_{i,j} = -E(OOP_{i,j}) - premium_{i,j} - \frac{1}{2} rVAR(OOP_{i,j}) + a \cdot u(H_{i,j})$$

Health care reform micro-simulation model for Connecticut
Key assumptions – Premiums

- Premium changes by market under the PPACA – 2014

Item	Individual	Small group
October 1, 2010 Changes	1.05	1.03
Essential Benefits Package	1.15	1.01
Women's Wellness	1.05	1.02
Mandated Benefits	0.95	0.95
Temporary Reinsurance Program	0.90	1.00
Other	1.04	1.04
Total	1.13	1.05

  - MLR minimums of 80% for small group and individual

- Premium and medical claims trend at 5.5% consistent with CBO assumptions

Health care reform micro-simulation model for Connecticut
Key assumptions – Coverage

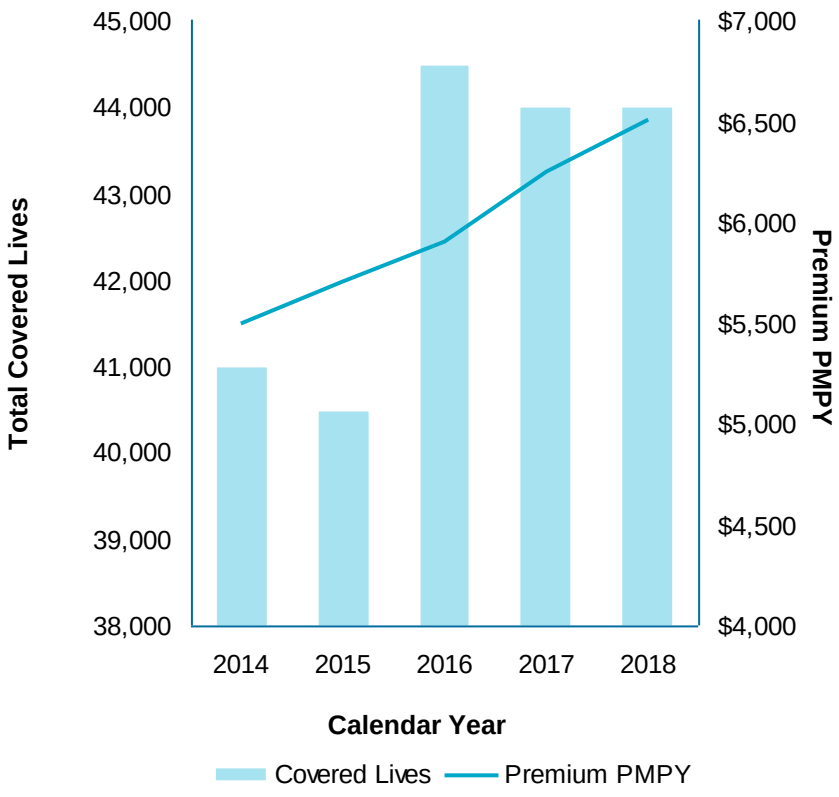
- Medicaid in 2014 and beyond at current level of effort
- Group insurance offer, eligibility, take-up, and contribution rates consistent with MEPS data for Connecticut by group size
- Utilization of health care services among the uninsured – assumed to be 60% of commercial, and assumed pent-up demand with first year costs 10% higher
- 25% of people purchasing individual coverage who are not subsidy eligible will purchase coverage through the Exchange, 100% of subsidy eligible purchasing individual insurance do so through the Exchange
- 5% of small employers who are not eligible for the tax credit will purchase coverage through the SHOP Exchange

Health care reform micro-simulation model for Connecticut
Key assumptions – Economic

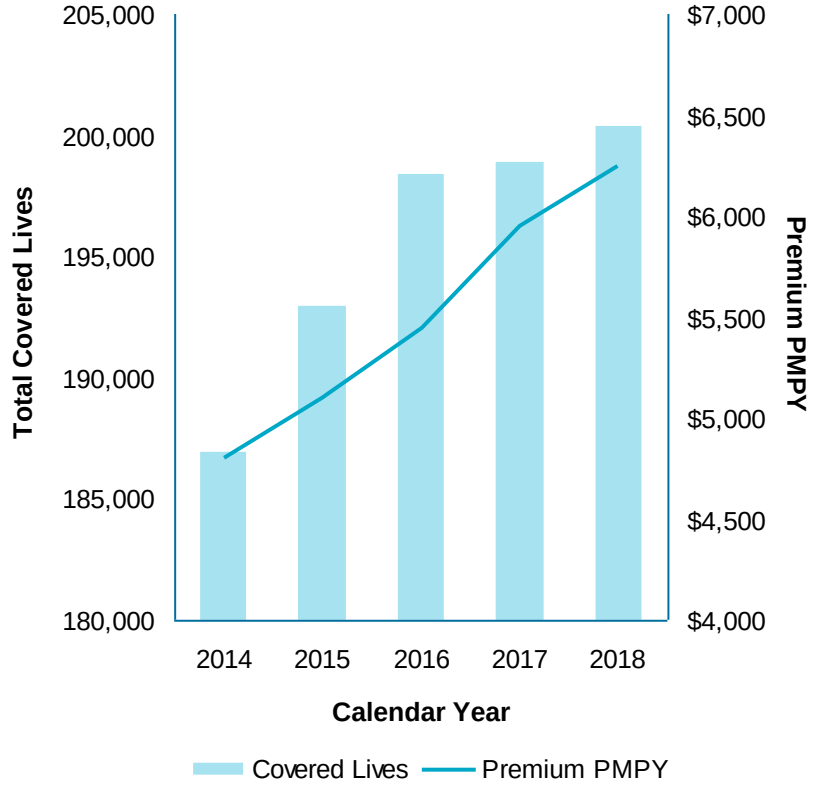
- Wage growth and CPI consistent with Social Security Trustees' Report
- Population growth consistent with US Bureau of the Census projections
- Income tax rates specific to Connecticut and include state, federal, FICA and Medicare taxes
- Penalties, premium credits and cost sharing subsidies consistent with the law

Health care reform micro-simulation model for Connecticut
Baseline results

SHOP Exchange



Individual Exchange



Health care reform micro-simulation model for Connecticut
Baseline results (cont'd)

- Uninsured rate in 2014 at 4% (roughly 150,000)
- Morbidity in individual market 12% higher in 2014
- Roughly 60% of total individual market enrolled in the Exchange
- Roughly 20% of the small group market enrolled in the Exchange
- 75% of individuals in the individual Exchange receiving premium subsidies

TASK 4a

To integrate high risk pools in the non-group market or maintain high risk pools separately

Task 4a – Integrating high risk pools
Background

- Connecticut's Health Reinsurance Association (HRA) is among the oldest in the country
- At year-end 2010, HRA had 1,870 enrolled
- HRA is funded through combination of member premiums (64%), assessments (33%), and federal grants (3%)
  - Premiums based on 150% of standard rate for similarly situated member in small group with 10 lives
  - Total funding in 2010 of $33.5 million
- Special health care plan reimburses providers at 75% of Medicare reimbursement to make plans affordable for low-income insureds
- HRA loss ratio (incurred claims/earned premium) of 259%
- Individual market has $362.5 million in premium and a 69% loss ratio

Task 4a – Integrating high risk pools
Modeling results

Impact of Enrolling High-Risk Pool Members into the Individual Market in 2014
($1,000,000s)

	Premium	Claims	Loss Ratio
Current Individual Market[1]	$ 362.5	$ 251.3	0.693
Individual Market Expansion 2014[2]	2.8	2.8	
Morbidity Adjustment	NA	1.12	
Current Market Projected to 2014	$ 1,015.0	$ 788.1	0.776
High Risk Pool at Standard Risk Rates and Reimbursement [3]	14.5	37.4	2.588
Combined Market	$ 1,029.5	$ 825.5	0.802
Premium Increase	0.2%		
Combined Market After Premium Increase	$ 1,031.9	$ 825.5	0.800
HRA Assessment	$ (11.0)		
Premium After Assessment	$ 1,020.9		
Premium Increase including Assessments	-1%		

1. Uses 2010 data from Supplemental Health Care Exhibits.
2. Based on Oliver Wyman's modeling results.
3. Uses 2010 audited financial statements with premiums divided by 1.50 to put at standard risk rates, and claims increased by 20% to reflect commercial reimbursement for the Special Health Care Plans.

Task 4a – Integrating high risk pools
Considerations

- The population insured in the HRA is very small relative to the projected individual market
- HRA members can be enrolled in the individual market with very little disruption
- State would have the option of continuing the HRA assessment
  - Difficult to get revenue to follow HRA member post 2014
  - How would subsidy be assessed when HRA members are subsumed into the individual market?
- Individual market will almost certainly be a lower cost option for HRA members post 2014, and they will have guaranteed access at standard rates and potentially premium and cost-sharing subsidies

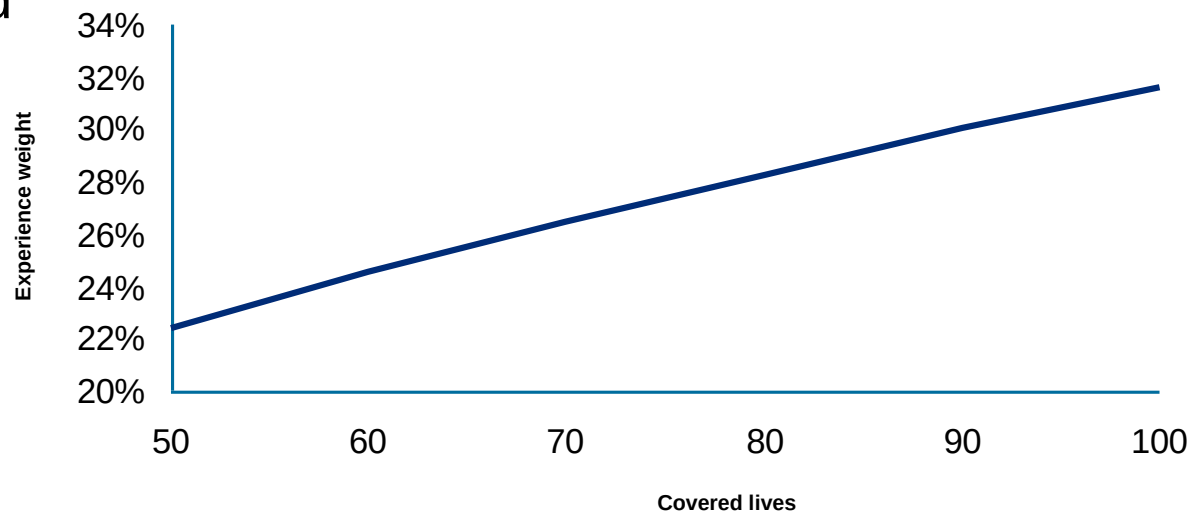
TASK 4b

Advantages and disadvantages of expanding the definition of small group from 50 to 100 employees prior to 2016

Task 4b – Expanding small group to 100 prior to 2016
Background

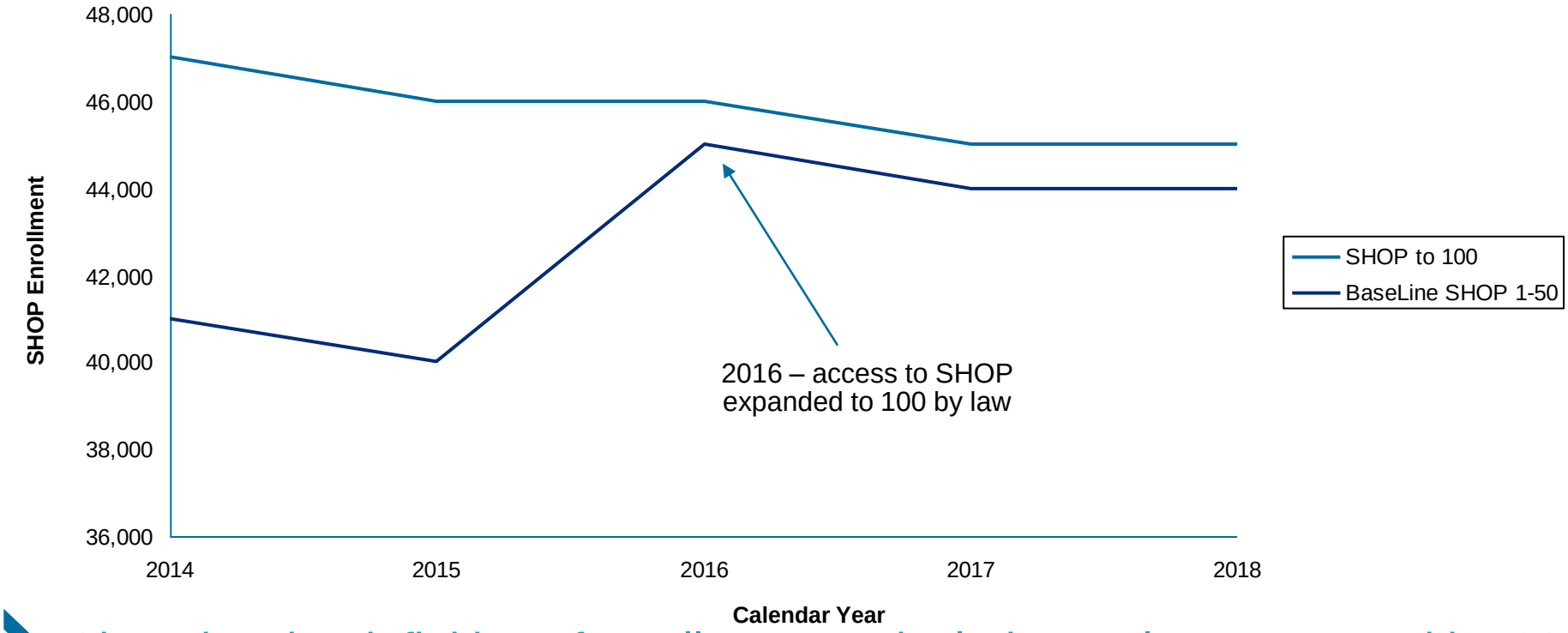
- Connecticut law defines small group as 1 to 50 employees. The PPACA gives states the option to define small group as up to 100 lives in 2014. If states take no action, the definition of small group changes to groups up to 100 lives in 2016.
- Mid-size employers in Connecticut represent roughly one-half the lives covered in small group, and morbidity is similar
- Mid-sized employers are experience rated

Own experience weight by group size
Connecticut carrier example



Task 4b – Expanding small group to 100 prior to 2016
Modeling results

SHOP Exchange enrollment
With and without groups to 100



- Changing the definition of small group to include employers up to with 100 lives would increase enrollment in the SHOP Exchange by about 6,000 lives or 15% for the first two years of operation

Source: Oliver Wyman HRM model output

Task 4b – Expanding small group to 100 prior to 2016
Considerations

- Advantages of opening the Exchange to groups to 100 prior to 2016
  - Moderate increase in SHOP Exchange enrollment of about 6,000 lives means fixed costs spread over larger base
  - More lives may encourage greater carrier participation in the SHOP Exchange
- Disadvantages
  - Market disruption as mid-sized groups that are currently experience rated become subject to the PPACA-adjusted community rating rules
  - Potential for deterioration of risk pool if mid-sized groups choose to self-insure

Changing the definition of small group to include employers with up to 100 lives would increase enrollment in the SHOP Exchange for the first two years of operation, but would subject the SHOP Exchange to increased risk of adverse selection

TASK 4c

Impact of an Exchange on employer-provided insurance and specifically the impact of employer penalties and tax credits

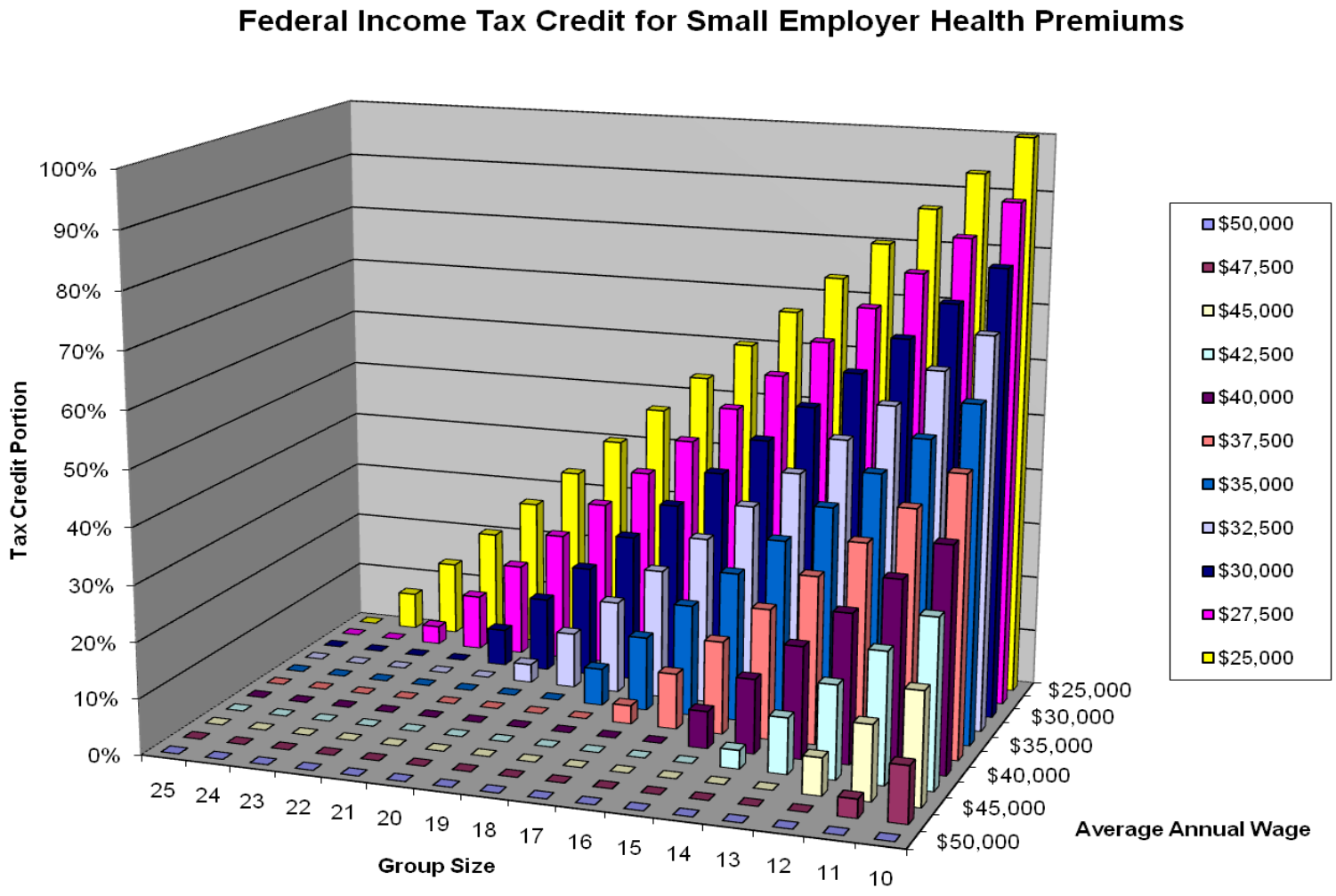
Task 4c – Impact of employer penalties and tax credits on employer-provided insurance

- Small employers (less than 50 fulltime equivalent employees) face no penalties, but may receive a federal tax credit, depending on size (25 employees and smaller) and average wage, but it's not large enough to significantly affect the offering of coverage
- Larger employers (50 or more) are subject to shared responsibility penalties if at least one fulltime employee obtains Exchange-based coverage and is eligible for financial assistance to better afford it, but the penalties are not large enough to significantly affect the offering of coverage

Task 4c – Impact of employer penalties and tax credits on employer-provided insurance (cont'd)

- The full credit for taxable employers is half (in 2014–15) the portion of premiums paid by the employer
  - The credit is less in 2010–2013 and less for tax exempt businesses
  - Tax credit expires at the end of 2015
- First, calculation limited to considering IRS-determined average single and family premiums (for 2010 in CT: $5,419 single and $13,484 family)
- Second, the full subsidy is available for groups of 10 or fewer employees, grading down by 1/15 per employee to reach zero for groups of 25 or more
- Third, the subsidy is further reduced for average annual wages of more than $25,000 grading down to zero for average annual wages of $50,000 or more
- The limitations work in combination, so that a group of 16 and an average wage of $37,500 receives no tax credit

Task 4c – Impact of employer penalties and tax credits on employer-provided insurance (cont'd)



Task 4c – Impact of employer penalties and tax credits on employer-provided insurance (cont'd)

- If an employer with 50 or more fulltime equivalent employees does not offer coverage to fulltime employee and their dependents
  - Subject to a penalty of $2,000 (indexed for years after 2014 for increases in average health insurance premiums) for each fulltime employee, except for the first 30 employees
  - For example, for an 80 employee firm the penalty would be $100,000 – an average of $1,250 per employee, much less than the employer cost of insurance

Task 4c – Impact of employer penalties and tax credits on employer-provided insurance (cont'd)

- If an employer with 50 or more fulltime equivalent employees:
  - Offers less than bronze level coverage to fulltime employees and their dependents, or
  - Offer bronze level or better coverage to fulltime employees and their dependents, but the contributions are not affordable for employees
    - Affordable if the employee contribution less than 9.5% of income
    - Safe harbor is the contribution for single coverage and the employee's W-2 wages
  - Employer is subject to a penalty of $3,000 (indexed) for each fulltime employee eligible for income-based assistance that enrolls in the Exchange
  - This penalty is subject to a limit of $2,000 (indexed) for each fulltime employee, except for the first 30 employees

TASK 4d

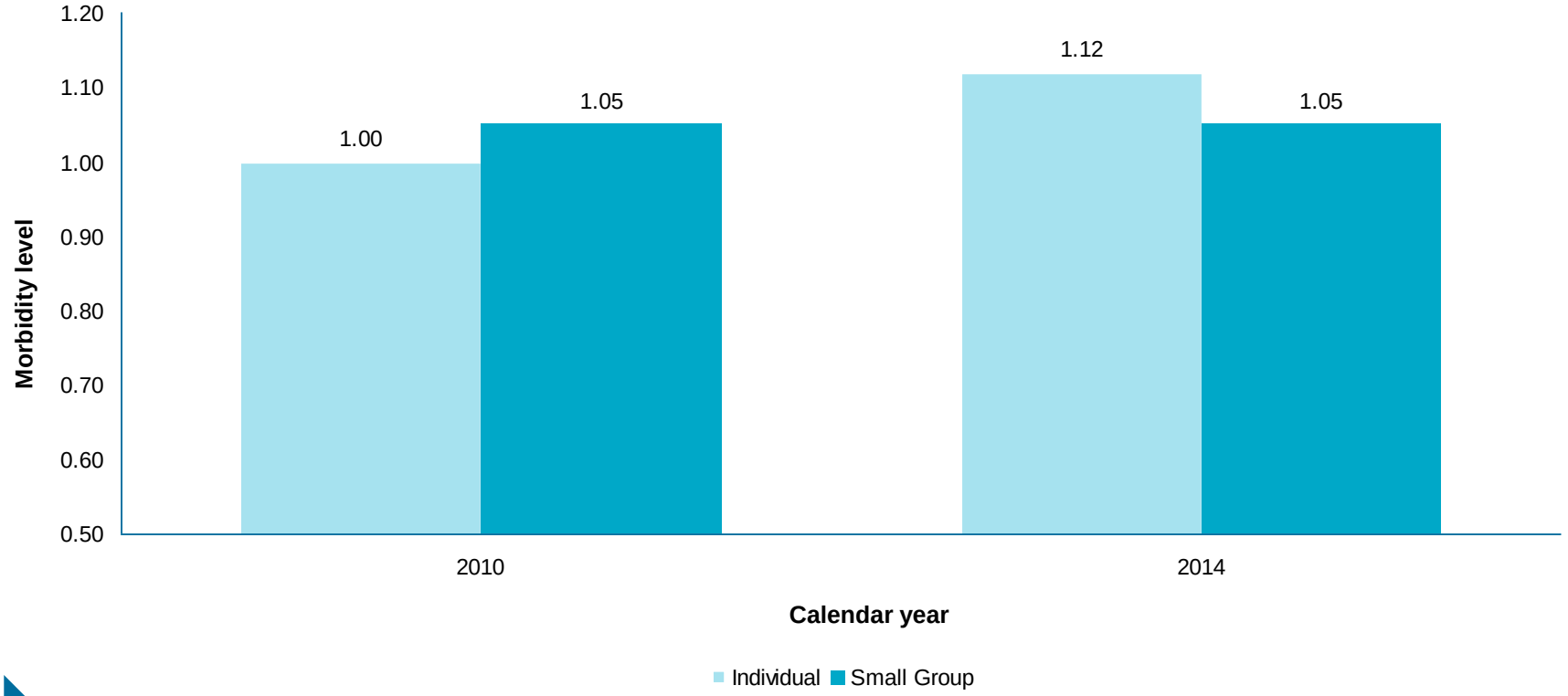
Implication of merging the markets for pricing in the small and non-group markets

Task 4d – Merging the individual and small group markets
Background

- The PPACA gives states the ability to merge the small group and individual risk pools at any time
- Currently, the Connecticut small group market is rated using modified community rating
- The individual market is medically underwritten

Task 4d – Merging the individual and small group markets
Modeling results

Morbidity by market – Baseline assumptions
1.00 = individual in 2010

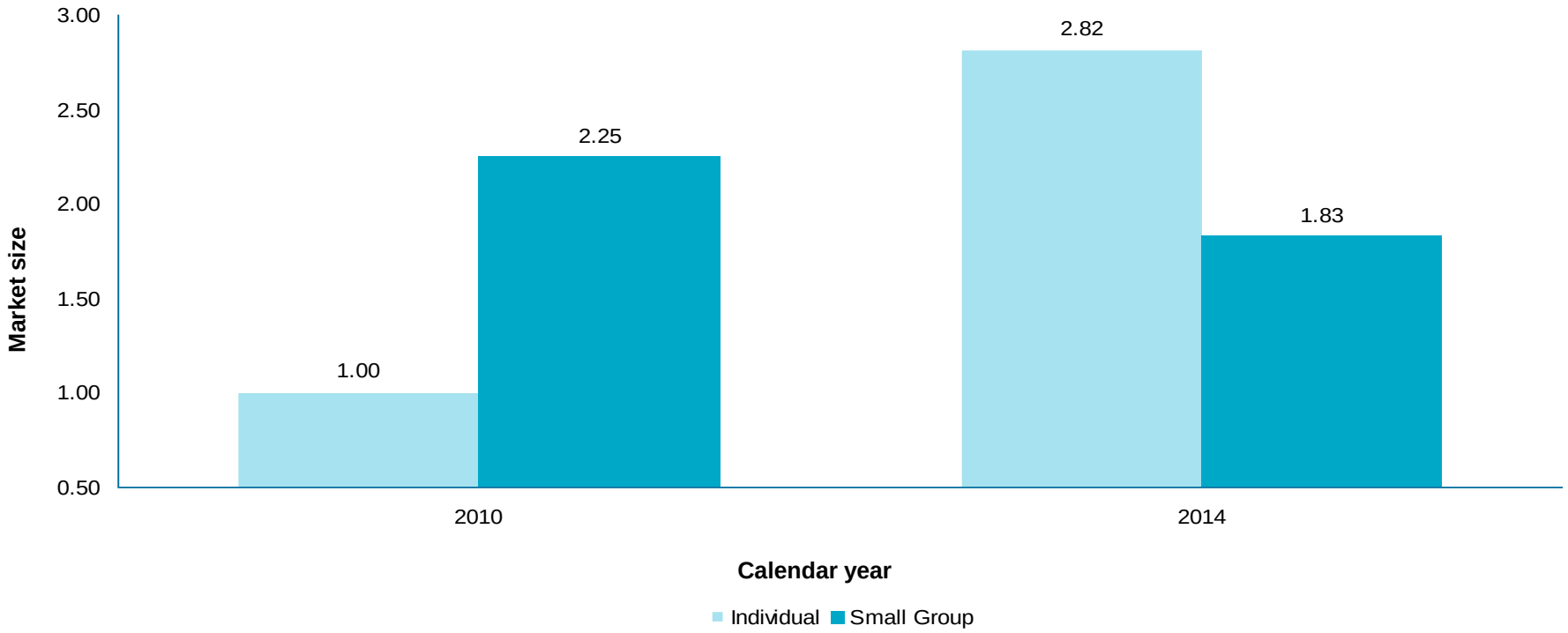


In 2010, the underwritten individual market has lower morbidity than the small group market, but in 2014, under guarantee issue, the risk profile changes, and morbidity in the individual market increases by 12%

Source: Oliver Wyman HRM model output

Task 4d – Merging the individual and small group markets
Modeling results (cont'd)

Size of respective markets – baseline assumptions
1.00 = individual in 2010



In 2010, the small group is 2.25 times the size of the individual market, but in 2014, the premium credits and the individual mandate result in growth in the individual market and a decline in the size of the small group market

Source: Oliver Wyman HRM model output

Task 4d – Merging the individual and small group markets
Modeling results (cont'd)

Market	Values Relative to Individual Individual Market in 2010 = 1.00 Size of Market	Morbidity with Separate Markets	Morbidity if Markets are Merged	Change in Premiums from Merging the Market
Individual	2.82	1.12	1.09	-2%
Small Group	1.83	1.05	1.09	4%
Total	4.65	1.09	1.09	0%

- Merging the markets would increase premiums in the small group market and reduce premiums in the individual market, but changes would be small

Source: Oliver Wyman HRM model output

Task 4d – Merging the individual and small group markets
Considerations

- Advantages of merging the individual and small group markets
  - Merging the markets would result in a larger pool of insureds which could provide more rate stability
  - Carrier administrative expenses associated with operating inside the Exchange could be lower, for example one product portfolio
  - Individuals leaving group coverage may be able to maintain their coverage
  - May encourage greater carrier participation
  - SHOP Exchange must allow employee choice among all carriers within a metallic level, similar to choice in the individual market

Task 4d – Merging the individual and small group markets
Considerations (cont'd)

- Disadvantages of merging the individual and small group markets
  - Merging the markets will result in additional rate shock – 4% higher rates for small employers, 2% lower rates for individuals
    - More rate shock for small employers will reduce employer offer and take-up rates, and encourage small employers to self-insure
    - Lower premiums for individuals reduces subsidies
  - Merging the markets may encourage small employers to drop coverage and have employees enroll as individuals
  - Those carriers specializing in only one market may choose not to operate in a merged market
  - A merged Exchange may make it more difficult to meet the needs of the respective markets
  - Merging the markets will complicate the operation of the Exchange, e.g., continuous open enrollment for small groups, but annual open enrollment for individual coverage

TASK 4e

Impact of the individual mandate to purchase health insurance and its influence on the market

Task 4e – Impact of the individual mandate
Background

- The PPACA imposes an individual mandate for all non-incarcerated individuals to maintain minimum essential coverage
- Those failing to maintain minimum essential coverage are subject to penalty – the larger of a flat annual penalty or a percentage of income

Year	Flat annual penalty	Percentage of income penalty
2014	$95	1.0%
2015	$325	2.0%
2016	$695	2.5%

- Children are assessed at one half the annual penalty, and the penalty for a family is capped at 300% of the flat annual penalty
- Penalty does not apply if coverage is deemed unaffordable (costs more than 8.0% of household income

Task 4e – Impact of the individual mandate
Modeling assumptions

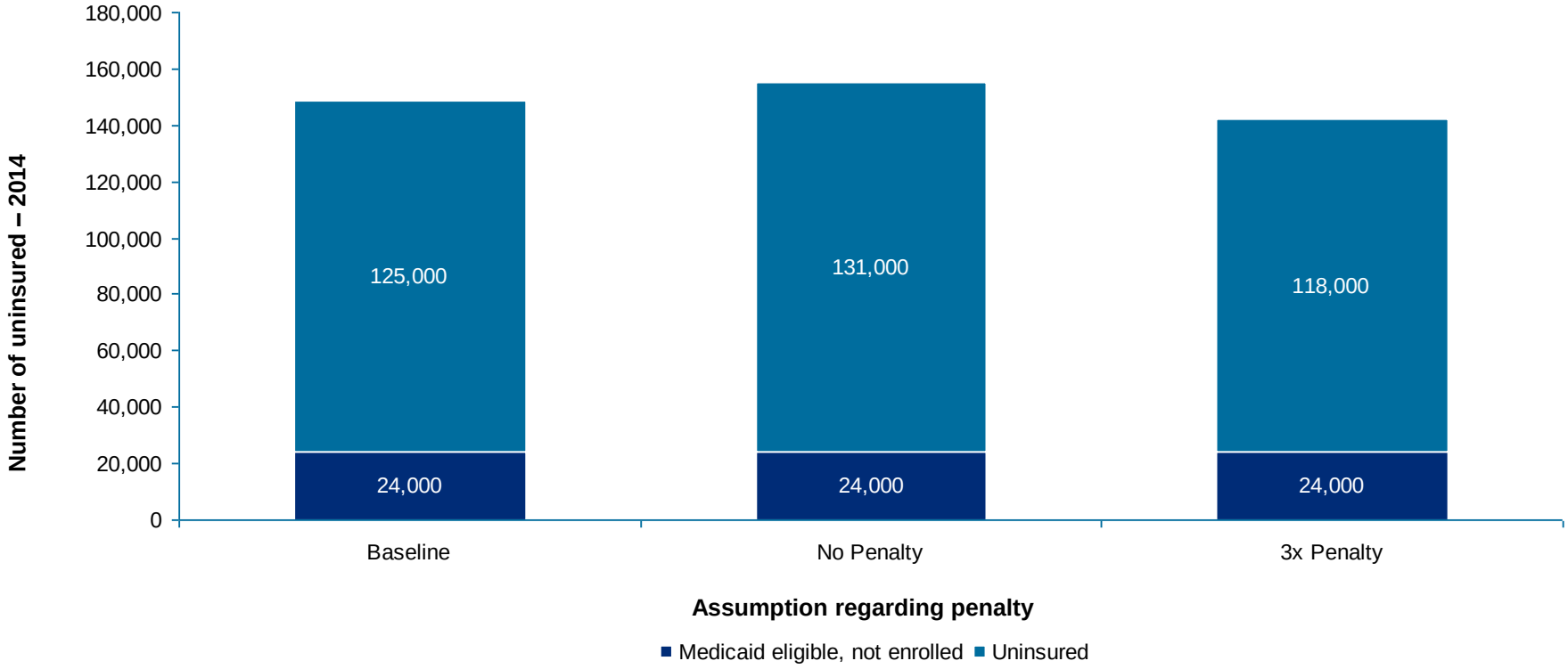
- Approach to modeling individual behavior based on maximizing utility

$$U_{i,j} = -E(OOP_{i,j}) - premium_{i,j} - \frac{1}{2} rVAR(OOP_{i,j}) + a \cdot u(H_{i,j})$$

- Varied factors *r* and *a* with income on the assumption that those with higher incomes are more likely/able to purchase insurance to protect against financial loss
  - In calibrating model to balance to 2010 environment, model parameters are quite different for those with incomes less than 200% FPL, but not dissimilar for those with incomes over 200% FPL
- The penalty is taken into account in the premium component of the formula when evaluating the options available to the individual – the utility of being uninsured includes the cost of the penalty

Task 4e – Impact of the individual mandate
Modeling results

Impact of penalty on number of uninsured



Our modeling shows that the penalty in 2014 is responsible for reducing the number of uninsured by about 5%

Source: Oliver Wyman HRM model output

TASK 4h

Impact of the exchange on insurer profitability and potential market exit

Task 4h – Impact of the Exchange on insurer profitability and potential market exit

Background

- The PPACA removes some of the key means some carriers had been using to compete in the market
  - Minimum MLR makes it difficult to attract business through the use of high commissions
  - Guarantee issue means using medical underwriting to select risks will no longer be allowed
  - Benefit standardization will make it more difficult to compete through product design
- Increased pricing transparency with standardized benefit levels and easier access to prices will put pressure on premiums
  - For the subsidized insureds, any costs in excess of the second lowest cost silver plan will be the responsibility of the insured
- Decisions that Connecticut makes regarding the design, operation and pricing of the Exchange will have an impact on carrier profitability and participation in the market

Task 4h – Impact of the Exchange on insurer profitability and potential market exit

Background

Individual Market in Connecticut -- 2010

Company	Covered Lives	Earned Premium (1,000s)	Loss Ratio	Underwriting Margin	Underwriting Margin at 80% MLR
Aetna	16,117	$ 31,486	0.655	16%	-2%
Assurant Group	2,543	9,952	0.708	-1%	-13%
ConnectiCare	8,649	30,916	0.695	5%	-8%
United	22,025	56,847	0.696	10%	-3%
WellPoint	55,665	193,189	0.801	8%	8%
Other	3,476	14,064	0.753	1%	-5%
Total	108,475	$ 336,453	0.755	8%	2%

Source: 2010 Supplemental Health Care Exhibits

In 2010, the loss ratio in the individual market was 0.755. Moving the loss ratio to the federal MLR of 0.800 would have resulted in a reduction in underwriting margin of roughly 6%, from 8% to 2%

Task 4h – Impact of the Exchange on insurer profitability and potential market exit

Background

Small Group Market in Connecticut -- 2010

Company	Covered Lives	Earned Premium (1,000s)	Loss Ratio	Underwriting Margin
Aetna	27,905	$ 108,098	0.812	6%
Cigna	36,943	97,832	0.922	-7%
ConnectiCare	53,603	244,627	0.804	4%
United	94,694	437,044	0.834	9%
WellPoint	82,533	488,072	0.873	9%
Other	2,749	20,819	0.780	5%
Total	298,427	$1,396,492	0.846	7%

Source: 2010 Supplemental Health Care Exhibits

- In 2010, the loss ratio in the small group market was 0.846, well in excess of the 0.800 federal MLR

Task 4h – Impact of the Exchange on insurer profitability and potential market exit

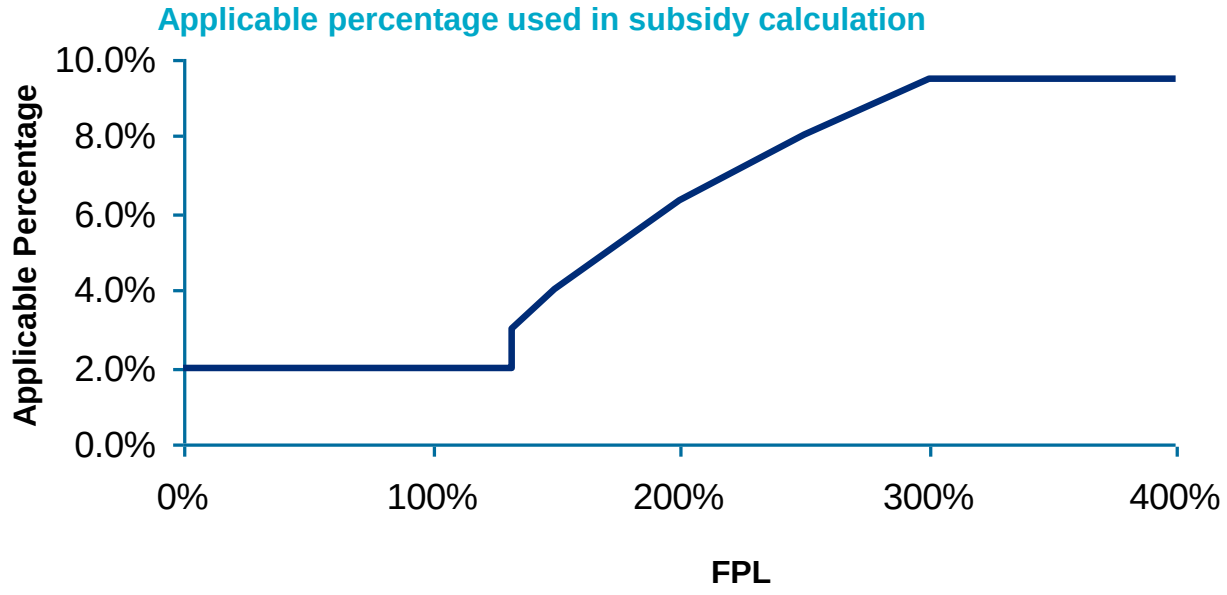
Considerations

- Exchange pricing and the financing mechanism will be key in determining the effect of the Exchange on insurer profitability
  - To the extent the Exchange charges more (less) for services than it costs carriers to deliver the same services, carrier profitability may be compromized (enhanced), particularly if some carriers stay out of the Exchange
  - Participating in the Exchange will likely increase an insurer's administrative costs – the need for IT interface with the Exchange, the need to obtain Qualified Health Plan certification for products
  - If Exchange is financed through an assessment on the market as a whole, mispricing of Exchange services will have a smaller effect
- In the individual market, smaller carriers with high administrative expense loads will be severely challenged to remain in the market
- The growth in the individual market will make that market attractive for carriers that can manage administrative expenses to the federal MLR

TASK 4i
Impact of the Exchange on household budgets

Task 4i – Impact of the Exchange on household budgets
Background

- The PPACA includes advance tax credits (premium subsidies) for individuals with incomes up to 400% FPL, and cost sharing subsidies for individuals with incomes up to 250% FPL
- The premium subsidy is equal to the difference between the second lowest cost silver plan in the individual market and the “applicable percentage” of the household income, varying by FPL



Task 4i – Impact of the Exchange on household budgets
Background (cont'd)

- Cost sharing subsidies provided to protect households with lower incomes from high out-of-pocket costs

Household income as a % of FPL	Actuarial value after Subsidy
138% to 150%	0.94
150% to 200%	0.87
200% to 250%	0.73

Task 4i – Impact of the Exchange on household budgets
Modeling results

Out-of-Pocket Spending for Health Care by FPL and Health Burden
Uninsured, Individual, and Small Group Markets Combined

Health Burden	FPL				
	Under 138%	139-200%	201-300%	301-400%	Over 400%
			2010		
Low	11%	5%	4%	4%	2%
Medium	16%	8%	11%	8%	7%
High	36%	15%	11%	7%	3%
Total	18%	9%	8%	6%	4%
			2014		
Low	6%	4%	9%	7%	4%
Medium	9%	5%	11%	9%	4%
High	10%	7%	11%	9%	4%
Total	8%	5%	10%	8%	4%

TASK 4 – QUESTIONS AND ANSWERS

TASK 5

Effect of large employers (>100 employees) seeking participation in the Exchange after 2017

Task 5 – Large employers seeking participation in the Exchange
Background

- The PPACA gives states the option to allow health insurance issuers to offer large group coverage through the Exchange beginning in 2017
  - Large employer pool, products, etc., can remain separate from small group and individual pools and products
  - Plans offered through the Exchange must be "Qualified," requiring, among other things, that the Essential Health Benefits package be covered, "metallic" tiers, network standards be met, same price inside and outside the Exchange (community rating)
- Large groups in Connecticut are experience rated or self-insure – 35% of enrollees in groups from 100 to 999 employees, and 89% of enrollees in groups 1000+ are covered by self-insured plans (MEPS 2009)
- The ACA provides additional incentive for groups to self-insure – avoid insurer fees ($8 billion in 2014 increasing to $14.3 billion in 2018) estimated at roughly 3% of premium

Task 5 – Large employers seeking participation in the Exchange
Background

- Large employers are relatively sophisticated purchasers with access to high quality health plans

Employers with employees in Connecticut

Firm size	Employers	Nationwide employees	Connecticut employees
1 to 50	239,680	839,164	820,439
51 to 100	1,901	140,825	116,002
101 to 250	1,262	201,816	124,207
251 to 500	604	217,283	85,487
501 to 1,000	475	342,623	88,777
1,001 to 2,500	558	907,680	115,217
2,501 to 5,000	405	145,5153	103,471
5,001 to 10,000	340	240,3822	92,821
10,001 to 25,000	287	4,580,015	119,403
25,000+	221	19,743,424	362,567
Total	245,733	30,831,805	2,028,391

Most likely to enroll in Exchange

Source: Oliver Wyman calculations with Dunn & Bradstreet data

Task 5 – Large employers seeking participation in the Exchange Considerations

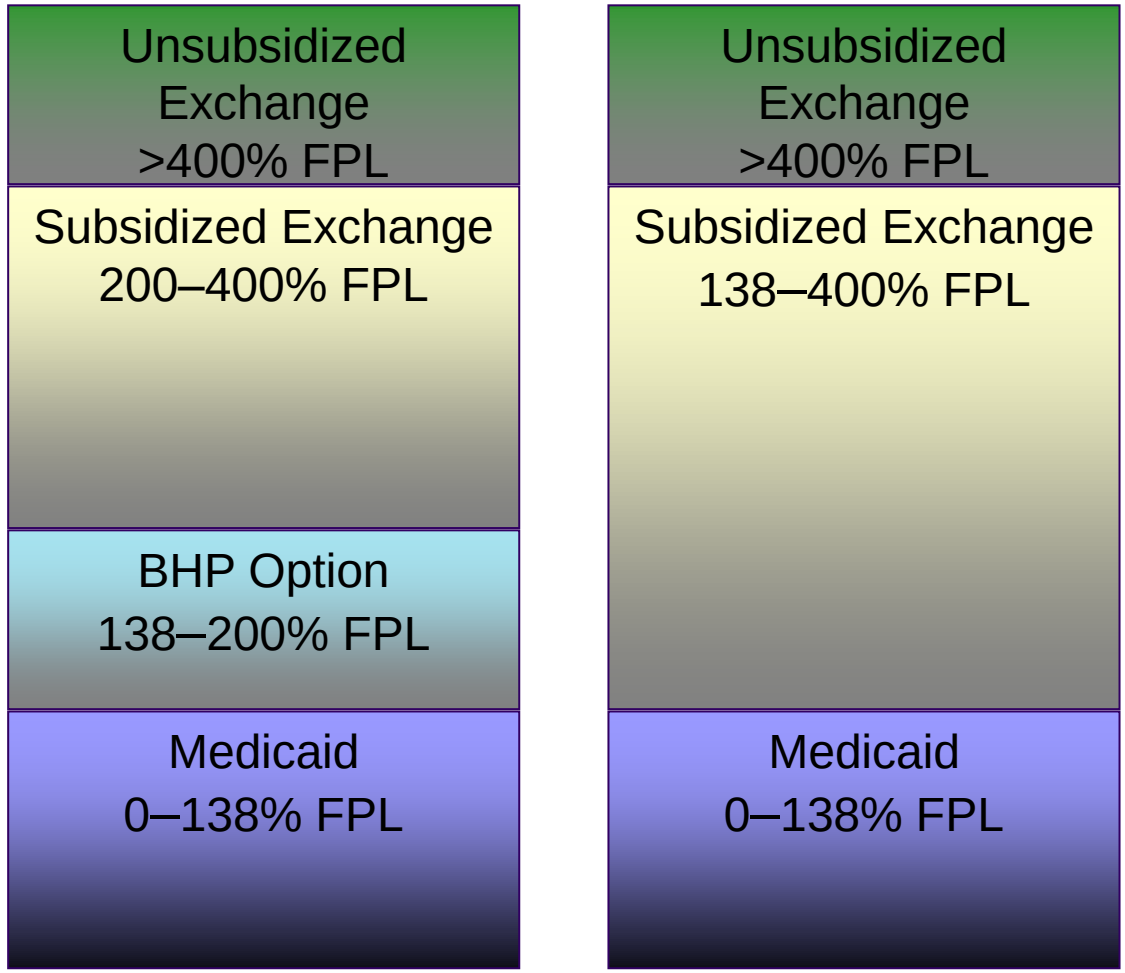
- Advantages of allowing large employers
  - Additional lives lowers fixed administrative costs per life
- Disadvantages of allowing large employers in the Exchange
  - Large employers' needs are very different from small employers' which may make it difficult for the Exchange to serve both markets
  - Difficult for Exchange to deliver administrative services at a lower cost than private market – some duplication of services likely, need for additional IT infrastructure
  - Opening Exchange to large employers would lead to significant adverse selection as this would allow large employers to select among self-insuring or an experience-rated premium outside of the Exchange, and a community-rated premium inside of the Exchange

TASK 5 – QUESTIONS AND ANSWERS

TASK 4f

Impact to markets and the Exchange if the Basic Health Program option is considered

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Overview



Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Summary

- The Basic Health Program (BHP) is an option for states to cover non-Medicaid eligible adults below 200% FPL (children < 200% FPL maintain Husky B eligibility thru MOE)
- Primary requirements
  - Must cover Essential Health Benefits
  - Premiums and cost sharing must be less than or equal to what would be available to this population in the Exchange
- The financial feasibility of the BHP option is dependent upon the size of the differential between a state's Medicaid provider reimbursement rates and the prevailing commercial rates
- Advantages of implementing a BHP
  - Reduce premiums and cost sharing for this low-income population
  - Leverage existing Medicaid delivery system
  - Less disruption of care at 138% FPL cusp

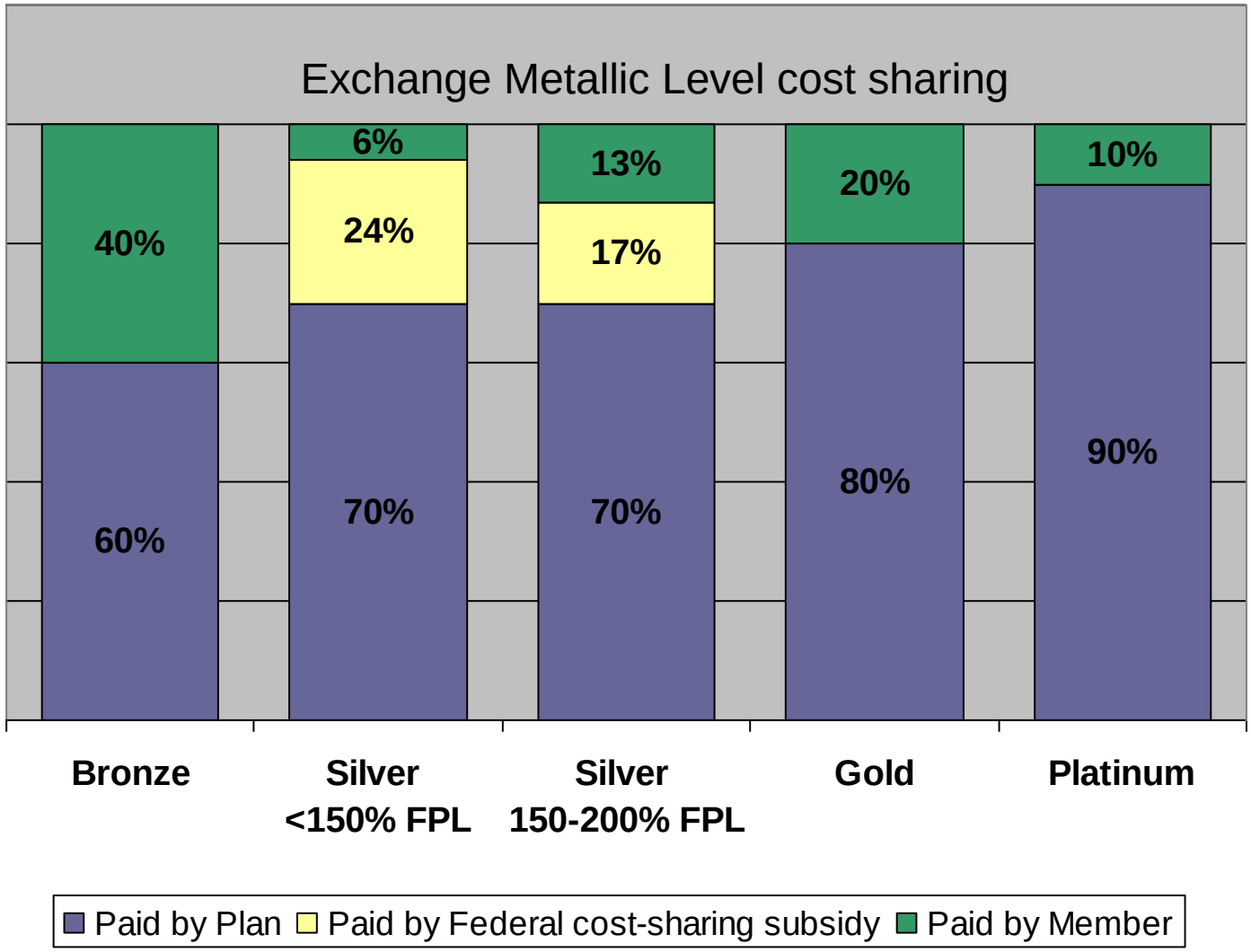
Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Background

- BHP in PPACA Legislation
  - Section 1331: Defines BHP
  - Modeled on Washington State BHP
  - Will probably require federal CMS waiver
- Federal Government will provide states with funding for a BHP
  - 95% of premium and cost sharing subsidies it would have provided to this population to states to operate a BHP
  - Only Essential Health Benefits are subsidized
  - States must pay for cost of additional state mandated benefits
- Implementing a BHP removes the 138%–200% FPL population from the pool of those eligible to enroll in the Exchange, which:
  - Reduces the size of Exchange-eligible population
  - Alters the composition of the Exchange risk pool

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Exchange premium subsidies

Income band	2014 Projected annual income	PPACA Section 1401 premium offset percentage	Monthly member premium	Annual member premium
138% FPL	$16,800	3.3%	$45	$540
150% FPL	$18,300	4.0%	$60	$720
200% FPL	$24,400	6.3%	$130	$1,560

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Exchange cost sharing subsidies



Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Exchange member cost

- Monthly member out-of-pocket costs in the Exchange, without a BHP
  - Significant jump from Medicaid to 138% FPL
  - Significant monthly costs below 200% FPL, even with subsidies
  - BHP can lower these costs for low-income band below 200% FPL

		Lower BHP band		Upper BHP band		Exchange band	
FPL band	**Medicaid**	**> 138%**	**< 150%**	**> 150%**	**< 200%**	**> 200%**	**< 400%**
Premium	$0	$45	$60	$60	$130	$130	$385
Cost sharing	$0	$30	$30	$70	$70	$140	$155
Total	$0	$75	$90	$130	$200	$270	$540

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – BHP cost scenarios

- Three BHP Scenarios
  - **Low cost scenario** with nominal member premiums and cost sharing
  - **Alternate scenario** with graded member premiums and cost sharing
  - Test case **Medicaid scenario** extends Medicaid to 200% FPL

	138%–150% FPL		150%–200% FPL	
Scenario	**Premiums**	**Cost sharing**	**Premiums**	**Cost sharing**
Low cost	$10	3%	$20	6%
Alternate	$20	5%	$60	12%
Medicaid	$0	0%	$0	0%

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Population

- Estimated size and characteristics of BHP eligible population by FPL band
  - Kaiser/Urban CPS data 2008 & 2009
  - Estimate 74,000 total eligible for BHP
    - Uninsured
    - Individually insured
  - Assume ESI population will not change significantly
  - Assume 70% take-up rate in BHP
  - Current Medicaid eligibility rules

138%–150% FPL	150%–200% FPL	Total
9,000	42,000	51,000
Average age 37	Average age 43	Average age 42

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Silver Level Exchange premium

- Estimate Exchange second lowest Silver-Level premium
  - Assume benefit level of average small employer group
  - 138%–150% FPL Exchange premium $395 PMPM
  - 150%–200% FPL Exchange premium $460 PMPM
- Calculate federal BHP subsidy amounts
  - Premium subsidy: PPACA Section 1401 – 95% of Exchange subsidy
  - Cost sharing subsidy: PPACA Section 1402 – 95% of Exchange subsidy

	138%–150% FPL	150%–200% FPL	Combined
BHP premium subsidy	$325	$350	$345
BHP cost sharing subsidy	$105	$85	$90
Total BHP subsidy	$430	$435	**$435**

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – BHP scenario results

- Assumed higher morbidity below 200% FPL
- Estimated the state BHP costs based on provider reimbursement relativities
  - DPH hospital reports
  - Mercer Medicaid physician encounter data studies
  - CT commercial carrier survey

	Low Cost	Alternate	Medicaid
BHP subsidy	$435	$435	$435
Net BHP cost	$355	$290	$405
Surplus/(Deficit)	$80	$145	$30

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Low cost scenario

- Low cost scenario monthly member out-of-pocket costs in the BHP
  - Out-of-pocket costs less than half of Exchange
  - $20 increase in monthly member cost from Medicaid to 138% FPL
  - Factor of 7x increase in member out-of-pocket spending at 200% FPL cusp

		Lower BHP band		Upper BHP band		Exchange band	
FPL band	**Medicaid**	**> 138%**	**< 150%**	**> 150%**	**< 200%**	**> 200%**	**< 400%**
Premium	$0	$10	$10	$20	$20	$130	$385
Cost sharing	$0	$10	$10	$20	$20	$140	$155
Total	$0	$20	$20	$40	**$40**	**$270**	$540

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Alternate scenario

- Alternate scenario to smooth out-of-pocket cost progression
  - Premiums of $20/$60 and Cost sharing of 5% and 12%
  - Factor of only 3x increase in member out-of-pocket spending at 200% FPL cusp

		Lower BHP band		Upper BHP band		Exchange band	
FPL band	**Medicaid**	**> 138%**	**< 150%**	**> 150%**	**< 200%**	**> 200%**	**< 400%**
Premium	$0	$20	$20	$60	$60	$130	$385
Cost sharing	$0	$15	$15	$40	$40	$140	$155
Total	$0	$35	$35	$100	**$100**	**$270**	$540

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – BHP results comparison

- Scenario trade-offs
  - Enrollment should increase as premiums decrease
  - Larger subsidy excess protects state from adverse experience deviation
  - Larger premiums and cost sharing increase potential for adverse risk enrollment

PMPM estimates	Low cost	Alternate	Medicaid
Federal subsidy	$435	$435	$435
Net state BHP cost	$355	$290	$405
Excess/(Deficit)	$80	$145	$30
Member cost	$40	$90	$0
Enrollment		Smallest	Largest
Average morbidity		Highest	Lowest

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Key considerations

- Use of excess of Federal subsidies over premiums restricted to:
  - Lowering member premiums and cost sharing
  - Additional state mandated benefits not subsidized
  - Increasing provider reimbursements
- State option to reduce Medicaid eligibility to 138% FPL
  - Estimated migration of additional 19,000 into BHP
    - Husky A parents
    - Husky A pregnant women
    - Employed disabled
    - Breast & cervical cancer
  - Saves state share of Medicaid cost
  - Would introduce premiums and copays to these groups

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Key considerations (cont'd)

- Subsidy surplus/(deficit) results primarily determined by
  - Variation of Silver Level premiums (second lowest) in the Exchange
  - Take-up rates and risk profile of enrolling BHP population
  - Redesign of Connecticut Medicaid provider fee schedules
- Network adequacy requirements and increased provider cost shifting
- State bears premium risk of a non-capitated BHP model
- Unknown Exchange risks
  - Persistency risk of BHP enrollees exploiting the 90-day grace period
  - Member churning among Medicaid, BHP and Exchange plans

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Key considerations (cont'd)

- Several undefined issues in PPACA Section 1331 need resolution
  - Definition of cost sharing subsidy: 95% or 100%
  - Risk adjustment rules and process
- Exchange impacts
  - Sustainability: Reduces size of remaining Exchange eligible population
  - Morbidity: May improve average enrolling Exchange risk above 200%
- Next steps
  - Decide whether to pursue the BHP option
  - Network adequacy analysis (in addition to Medicaid expansion impact)
  - Benefit design and cost sharing structure

Task 4f – Impact to markets and the Exchange if the Basic Health Program option is considered – Conclusion

- What is known about the PPACA at this stage, using
  - The assumptions about the unknowns of the PPACA, and
  - The actuarial assumptions in the pricing models:
    - Second lowest Silver Level premium in the Exchange
    - Costs of the BHP
- The BHP appears to be a financially feasible option for the State to consider at this stage
- However, forthcoming regulations and changing market conditions can alter this preliminary conclusion

TASK 4f – QUESTIONS AND ANSWERS

TASK 7

Develop a financial model for the Exchange (cash flow) to understand the administrative charges necessary to be financially self-sustaining by January 2015 and offer recommendations regarding the options to receive such charges

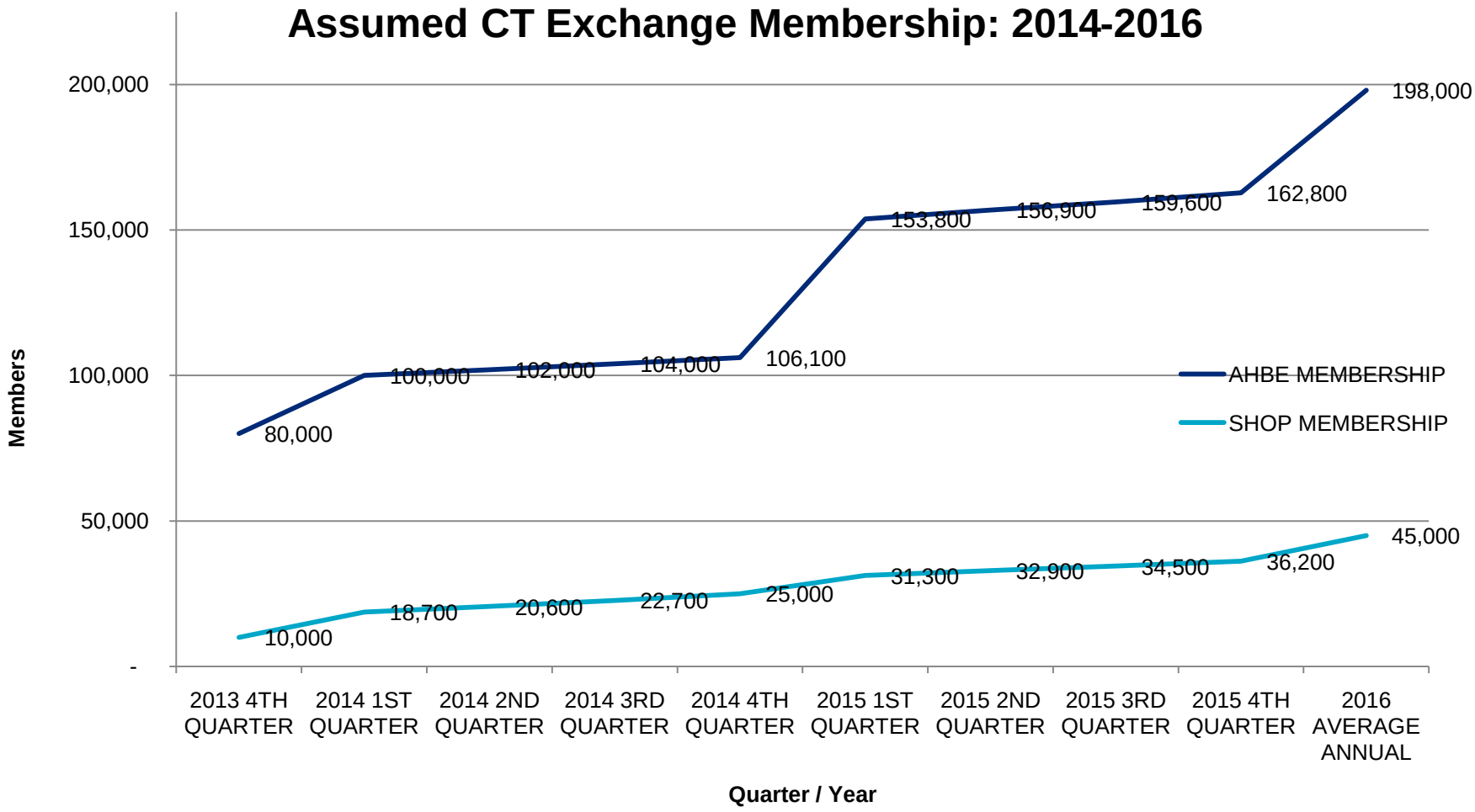
Task 7 – Develop a financial model for the Exchange

- The PPACA requires Exchanges to be financially self-sustaining by January 1, 2015
- State needs to recognize that Exchange cost is contingent upon a number of unknown factors
  - Assumed Exchange membership
  - Administrative structure of the Exchange
  - Mandates in authorizing legislation (Public Act 11-53)
- Budget model needs to address this uncertainty in its initial estimate
- State must be able to adjust cost estimates to reflect changes in major inputs

Task 7 – Develop a financial model for the Exchange (cont'd)

- Develop a model projecting Exchange operating costs and potential revenues
- Model incorporates estimates of Exchange cash flow including revenue, expenses and resultant reserves to support financial self-sufficiency by January 1, 2015
- Model will test a number of potential revenue sources against projected Exchange operating costs

Budget model assumptions – Exchange membership



Budget model assumptions – Exchange structure and costs

- Structure of Connecticut's Exchange
  - Single Exchange (consolidated administration of AHBE and SHOP Exchanges)
  - Quasi-public
- Staffing and outsourcing
- Information technology development
- Insurance broker reimbursement

Budget model structure

- Budget requires a number of estimates of cost inputs
- Strategies used to account for unpredictability of certain budget model estimates:
  - Model assumes a range of costs associated with each budget component. Developed “High” and “Low” scenarios
  - Final budget tool explicitly identifies major assumptions
  - Assumptions can be adjusted by State planning staff

Budget model results – Total costs

- **Assumed Gross 2014 cost:** $21.3 to $30.4 million
- **Assumed Gross 2015 cost:** $21.7 to $27.2 million
- **Assumed Gross 2016 cost:** $24.5 to $30.2 million

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
FTE	9.25	18.5	44.0	44.0	44.0
GROSS COST	$17,472,645	$24,967,483	$30,402,601	$27,232,667	$30,225,121
STATE/HBE COST	$0	$2,020,565	$3,186,463	$26,967,513	$29,938,036
LOW ESTIMATE					
FTE	9.0	18.0	29.0	29.0	29.0
GROSS COST	$15,179,600	$17,602,625	$21,315,143	$21,711,633	$24,525,979
STATE/HBE COST	$0	$514,396	$630,524	$21,526,025	$24,325,020

* State/HBE costs in 2012 and 2013 related to required Medicaid match for several small Exchange functions and operation of a Navigator program which is not eligible for Federal Exchange funding.
* *Difference between Gross and State/HBE cost in 2015 and 2016 related to access to Federal Medicaid matching funds for some small Exchange functions.

Budget model results – Human resource costs

- Exchange salary and wages:
  - Assumes 29.0 to 44.0 FTE by 2016
  - Salary estimates through Federal Bureau of Labor Statistics data
- Exchange fringe benefits
  - Assumed at 35.0% of salary cost
- State of Connecticut support staff needs
  - Executive Office of Governor
  - Department of Social Services
  - Connecticut Insurance Department
  - Connecticut Department of Information Technology

Budget model results – Exchange administrative expenses

- Consultant costs
  - Information technology support
  - Modeling/actuarial support
  - Marketing and outreach activities
- General administrative costs
  - Equipment
  - Supplies
  - Travel
  - Rent
  - Printing

Budget model results – Contracted costs

- Budget model assumes that many Exchange functions will be contracted from third party vendors
  - Call center/premium billing
  - Web site maintenance and improvement
  - State eligibility chargeback
  - Appeals program
  - Navigator/outreach efforts
  - Marketing and communication

Budget model results – Information technology (IT) development

- IT costs are assumed through the creation or purchase of the following functions:
  - Exchange portal (website development)
  - Plan management functions
  - Financial management functions
  - Business Rules Management System (BRMS)
  - Customer Relationship Management (CRM) system
  - Enterprise Resource Planning (ERP)
  - Interaction with Federal data services hub
- Additional Costs:
  - System hosting
  - Procurement support
  - Contractor Independent Verification and Validation (IV&V)
  - Project management

Budget Model Results – Generating sustainable revenue for Connecticut's Exchange – Elements of an effective strategy

- The PPACA requires the Exchange to be financially self-sustaining by January 1, 2015
- Standards for effective financing strategy:
  - **Stability:** Will strategy generate sufficient revenue?
  - **Simplicity:** Is administration and compliance with method easy?
  - **Fairness:** Are insurers, consumers and others who benefit from the Exchange paying an appropriate amount to support its operation?
  - **Secondary Effects:** Does strategy unnecessarily distort the insurance market in Connecticut?

Budget model results – Revenue options

- **Exchange Premium Assessment:** Monthly fee charged to all Exchange members, calculated as a percent of premium
- **Exchange Transaction Charge:** Flat monthly fee charged to all Exchange members
- **Health Insurance Carrier Participation Fee:** Fixed or tiered fee charged to all insurance carriers participating in the Exchange
- **Health Insurance Carrier Non-Participation Fee:** Fixed or tiered fee charged to all insurance carriers not participating in the Exchange
- **Broad-based Health Insurance Carrier Fee:** Assessed upon all health coverage purchased in Connecticut
- **Advertising Revenue:** Charging advertisers for access to Exchange web-tool and would be a supplemental revenue source

Budget model results – Recommended revenue options

- Mercer/HMA team recommends the following methods of generating revenue for Connecticut's Exchange:
  - **Exchange Premium Assessment:** 2.5% assessment on premiums for health coverage purchased through the Exchange
  - **Health Insurance Carrier Nonparticipation Fee:** charged to health insurance carriers who choose not to offer qualifying coverage through Connecticut's Exchange

Budget model results – 2012 through 2016

	2012	2013	2014	2015	2016
CASELOAD					
AHBE CONTRACTS	0	14,000	72,118	110,793	138,600
SHOP CONTRACTS	0	1,325	11,528	23,850	23,850
MEMBERS	0	90,000	124,775	192,000	243,000
MEMBER MONTHS	0	270,000	1,497,300	2,304,000	2,916,000
EXCHANGE PREMIUMS	$0	$0	$603,842,500	$980,235,000	$1,330,200,000
OPERATING REVENUE					
FEDERAL EXCHANGE GRANTS	$17,472,645	$24,967,483	$30,402,601	$0	$0
PREMIUM ASSESSMENT	$0	$0	$15,096,144	$24,506,067	$33,254,955
CARRIER NON-PARTICIPATION FEE	$0	$0	$1,000,000	$1,000,000	$1,000,000
TOTAL OPERATING REVENUE	*$17,472,645*	*$24,967,483*	*$46,498,745*	*$25,506,067*	*$34,254,955*
NON OPERATING REVENUE					
INVESTMENT INCOME	$0	$0	$160,961	$307,876	$337,066
OTHER NON-OPERATING REVENUE	$0	$0	$0	$0	$0
TOTAL NON-OPERATING REVENUE	*$0*	*$0*	*$160,961*	*$307,876*	*$337,066*
OPERATING EXPENSES					
HUMAN RESOURCE EXPENSE	$2,489,250	$4,085,988	$5,487,959	$5,412,127	$5,530,430
CONSULTING COSTS	$2,950,000	$3,700,000	$4,450,000	$2,125,000	$2,125,000
EXCHANGE ADMINISTRATIVE EXPENSE	$138,395	$277,865	$347,660	$294,960	$294,960
CALL CENTER EXPENSE	$0	$1,353,630	$7,746,101	$12,219,469	$15,841,581
WEB SITE CREATION/MAINTENANCE	$0	$0	$1,000,000	$750,000	$500,000
PREMIUM BILLING	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
APPEALS PROGRAM	$0	$0	$903,381	$432,736	$422,375
COMMUNICATIONS / MARKETING	$0	$0	$1,000,000	$1,000,000	$1,000,000
NAVIGATOR EXPENSE	$0	$2,000,000	$3,000,000	$2,000,000	$1,500,000
OUTREACH EXPENSE	$0	$2,000,000	$1,750,000	$250,000	$125,000
IT DEVELOPMENT COST	$11,895,000	$11,050,000	$3,392,500	$1,357,125	$1,424,975
TOTAL OPERATING EXPENSES	*$17,472,645*	*$24,967,483*	*$30,402,601*	*$27,232,667*	*$30,225,121*
OPERATING PROFIT / (DEFICIT)	***$0***	***$0***	***$16,257,105***	***($1,418,723)***	***$4,366,900***
NET ASSETS BEGINNING OF YR	***$0***	***$0***	***$0***	***$16,257,105***	***$14,838,382***
NET ASSETS END OF YEAR	***$0***	***$0***	***$16,257,105***	***$14,838,382***	***$19,205,282***

Budget model results – Additional recommendations

- Mercer/HMA team recommends the following elements to help ensure that the Connecticut Exchange is self-sustaining by 2015:
  - Timely hiring of key staff and development of strong Exchange platform
  - Sufficient funds allocated for education and outreach activities in 2014
  - Participation of key health insurance carriers and availability of a sufficient choice of health plans
  - Partnering with health insurance brokers
- The Mercer/HMA budget model assumes successful implementation of all these strategies in the development of its caseload, cost and revenue estimates

TASK 7 – QUESTIONS AND ANSWERS

TASK 6

Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut

- The analysis considered a wide range of health systems expected to exist in the marketplace at the time of the Exchange
- Some of these systems have been around for years and others are now just being planned
- The Exchange functions as the hub of access to both public and private insurance

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- The health coverage initiatives analyzed are varied and include public and private systems

Health Coverage Initiatives Examined
Partnership Plans
Health Connections
Pre-existing Condition Health Insurance Plan
Charter Oak
Connecticut AIDS Drug Assistance Program (CADAP)
HUSKY B > 300% FPL

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

Health coverage initiative	Description	Type of health coverage		Length of operation		Governing source		Service area		Current enrollment
		Partial	Full	Less than 5 years	More than 5 years	Public	Private	Statewide	Regional	
Exchange	*State-based competitive marketplace for individuals and small businesses to purchase private health insurance*		✓	✓		✓	✓	✓		*Unknown*
Partnership plans	Health care benefit plan offered to non-state public employers or nonprofit employers and their retirees		✓	✓		✓		✓		Unknown
Health connections	Exchange for small employers with 3 to 100 employees to purchase health insurance at competitive pricing		✓		✓		✓	✓		75,000
Pre-existing condition insurance plan	Health benefit package for those with a pre-existing qualified, diagnosed medical condition and uninsured for six months		✓	✓		✓		✓		103
Charter Oak Health Plan	State subsidized health benefit plan on a guaranteed basis with no pre-existing condition exclusion periods		✓	✓		✓		✓		8,000
Connecticut AIDS Drug Assistance Program	Medication program for enrollees HIV/AIDS and with incomes below 400% federal poverty level (FPL)	✓			✓	✓		✓		2,000
HUSKY B >300% FPL	Connecticut's health insurance program for children in families with incomes over 185% FPL. Those over 300% FPL may "buy into" HUSKY B.		✓		✓	✓		✓		1,730

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- Partnership Plans
  - Provide access and information to Partnership Plans through Exchange:
    - State flexibility in design to include in the Exchange
    - Reduce administrative burden by having exchange provide access to program
    - Maintains separate identity from the exchange and competes with exchange's purchasing power
  - Actively refer to partnership plans using the Navigator:
    - Leverages Navigator's role to benefit Partnership Plan
  - Incorporate Partnership Plans into Exchange:
    - Current Federal and State law would require plan to be licensed
    - If licensed, program can be designed for future integration with Exchange
    - Avoids duplication of efforts for similar programs
    - Garners purchasing power from exchange volume to share with the partnership plans
    - May dilute "identity" of Partnership Plans and intent of state law

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- Health Connections
  - Provide access and information only to Health Connections through Exchange:
    - Private program whereby access through the Exchange is not an option
    - Maintains independence by remaining outside the Exchange
  - Actively refer to Health Connections using the Navigator**:**
    - Not an option
  - Incorporate Health Connections into Exchange**:**
    - Operate as a subcontractor to operate small group Exchange
    - Brings years of experience to the Exchange, including best practices

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- Pre-existing Condition Insurance Plan (PCIP)
  - Provide access and information only to PCIP through Exchange:
    - The program will cease operations by December 31, 2013
    - Existing members can be transitioned into the Exchange
  - Actively refer to PCIP using the Navigator:
    - The program will cease operations by December 31, 2013
    - Existing members can be transitioned into the Exchange
  - Incorporate PCIP into Exchange:
    - Ensures continuity of coverage for current enrollees
    - Existing health plan relationship already established under this program
    - The Department of Social Services can share experiences of running this program with the exchange board

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- Charter Oak Health Plan (COHP)
  - Provide access or information only to COHP through Exchange:
    - Exchange could serve as only an access point or referral resource for the existing Charter Oak Health Plan
    - Enrollees would not be eligible for federal premium and cost sharing subsidies
  - Actively refer COHP using the Navigator:
    - The Exchange can inform potential enrollees of their options under Medicaid and CHIP, including COHP enrollees of their options under the Exchange
  - Incorporate COHP into Exchange:
    - Connecticut could discontinue the COHP
    - Transition CHOP enrollees who are not eligible for Medicaid into Exchange
    - Only enrollees with incomes less than 400% of the federal poverty level (FPL) will qualify for premium and cost-sharing subsidies
    - Connecticut would realize budget savings by discontinuing COHP

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- Connecticut AIDS Drug Assistance Program (CADAP)
  - Provide access and information only to CADAP through Exchange:
    - Individuals with incomes less than 400% FPL will be eligible for federal premium and cost-sharing subsidies for health plans sold on the exchange
    - CADAP could provide additional premium assistance and cost sharing to individuals with HIV/AIDS who are enrolled in an Exchange plan
    - CADAP could wrap prescription drug coverage for HIV/AIDS medications that are not covered by an Exchange plan (for example, off-label medications)
  - Actively Refer to CADAP using the Navigator:
    - The Exchange can inform potential enrollees of their options under CADAP
  - Incorporate CADAP into Exchange:
    - Connecticut could mandate that plans sold within the Exchange cover the CADAP drug formulary
    - The PPACA does not require that health plans (either sold on or off an exchange) use a specific drug formulary
    - Connecticut may be required to assume those costs

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- HUSKY B >300% FPL
  - Provide access and information only to HUSKY B through Exchange:
    - Exchange determine eligibility for state-sponsored programs including for those eligible for HUSKY B
  - Actively refer to HUSKY B using the Navigator:
    - The Exchange can inform potential enrollees of their options under Medicaid and CHIP, including HUSKY B
  - Incorporate HUSKY B into Exchange:
    - Connecticut could decide to incorporate all, or parts of, the HUSKY B program into the Exchange
    - As soon as the Exchange becomes certified in 2014, Connecticut may wish to transition HUSKY B – Tier 3 enrollees into the Exchange
    - HUSKY B, Tiers 1 and 2 are subject to the PPACA's children's eligibility maintenance of effort requirements through September 30, 2019

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- Key Considerations
  - Overlap of eligible enrollees
    - Current populations in coverage initiatives would be also eligible for coverage under the individual and small business Exchange and qualify for subsidies or tax incentives
  - Competition of products/services
    - Products and services currently being offered through the coverage initiatives would also be offered under the individual and small business Exchange
    - The Exchange can consider incorporating some or all these coverage initiatives into their program to eliminate competition and or streamline offerings of products for potential enrollees

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- Duplicate administrative functions
  - Achieve some administrative budget savings by incorporating the coverage initiatives into the Exchange
  - Streamlining consumer assistance, marketing, enrollment and eligibility functions

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- Recommendation
  - Weigh each option of current programs
  - Determine what is best for the State, the Exchange, the individual and small employers and the established coverage initiative.
  - Further analysis with other public and private programs
  - Analysis will assist the Exchange Board in their role in providing accessible and affordable health care coverage to the residents and small employers in Connecticut
  - Ensure that the plan for interaction is efficient, cost effective and customer focused

TASK 6 – QUESTIONS AND ANSWERS

NEXT STEPS

Next steps

- December 16 – Meeting with Exchange staff to discuss final report
- Final report
- Conclusion of project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